No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Should this Court grant certiorari to decide whether the Fourteenth Amendment's Equal Protection Clause is violated by New York laws that permit only one class of mentally competent, terminally ill patients to choose to hasten death with medical assistance — those on life support — when there is no conflict among federal courts or between a federal court and a state court of last resort on this issue, when the law continues to be developed by the lower courts, and when the court below properly applied equal protection principles?

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STATEMENT OF THE CASE

This case challenges New York's statutes prohibiting assisted suicide as violative of the Fourteenth Amendment's guarantees of equal protection and liberty. Respondents assert that mentally competent, terminally ill adults have a protected liberty interest in choosing to hasten death in a certain, humane and dignified manner. This right necessarily entails medical assistance. Further, respondents allege that the challenged New York laws, which prohibit physicians from

prescribing medications that can be self-administered by mentally competent, terminally ill citizens of New York who wish to hasten impending death, but permit physicians to assist New York citizens in their choice to hasten death if they are dependent upon life support, violate the Equal Protection Clause of the Fourteenth Amendment.

FACTUAL BACKGROUND

I. RESPONDENT DOCTORS AND THEIR PATIENTS

Respondents Quill, Klagsbrun, and Grossman are New York doctors who regularly care for terminally ill patients. Each of these doctors encounters cases in which his professional responsibilities dictate that he honor competent, terminally ill patients' requests for prescription medication to hasten death:

> It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational, and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death when palliative care becomes ineffective or unacceptable if the patient so chooses.

JA 39 (Declaration of Dr. Quill); *accord* JA 59 (Dr. Klagsbrun); JA 73 (Dr. Grossman).

Each of these doctors has refused to honor such requests for fear of criminal prosecution under sections 125.15(3) and 120.30 of the New York Penal Law. These sections criminalize the assistance of a physician in committing or attempting suicide, although neither suicide nor attempted suicide is criminalized, and the term "suicide" is not defined. Dr. Quill

was investigated by a New York grand jury for one instance where he did render assistance. JA 39-42.

The original plaintiffs included three individuals then in the final stages of terminal illness: Jane Doe, George A. Kingsley, and William A. Barth. Ms. Doe was a 76-year-old retired physical education instructor who was being strangled to death by a large cancerous tumor that had wrapped around her right carotid artery and was slowly collapsing her esophagus. JA 12, 93-95. Mr. Kingsley was a 48-year-old publishing executive suffering from a number of AIDS-related diseases, including cryptosporidiosis (a parasitic infection causing severe fevers and diarrhea), cytomegalovirus retinitis (a virus that attacks the retina and causes blindness), and toxoplasmosis (a parasitic infection causing lesions on the brain). JA 12, 86-88. Mr. Barth was a 28-year-old former fashion editor suffering from several AIDS-related diseases, including Kaposi's sarcoma skin lesions, cytomegalovirus of the stomach and colon, microsporidiosis, AIDS-related pneumonia, and cryptosporidiosis. JA 13, 82-84.

Ms. Doe, Mr. Kingsley, and Mr. Barth — mentally competent adults in the final stages of terminal illness — sought to alleviate their suffering and hasten death by self-administering drugs prescribed by their physicians. JA 12-13, 84-85, 88-90, 96-97. They died before the district court issued its ruling. Petition for Writ of Certiorari at 3 n.1.

Respondents continue to assert the constitutional claims of their other terminally ill patients. JA 15-17, 141-43, 154-56. *See Doe v. Bolton*, 410 U.S. 179, 187-89 (1973).

II. THE ASSISTANCE SOUGHT BELOW VS. THE ASSISTANCE NEW YORK PERMITS

Dr. Quill has substantial experience assisting patients to die through disconnection of life support and infusion with

medications, a means of hastening death explicitly authorized by New York law. These authorized practices are indistinguishable from the class of physician-assisted suicides prohibited by New York's penal statute. JA 104, 107-08, 116. First, both begin with careful clinical assessment of the patient's prognosis, mental competence and treatment alternatives:

> The removal of a life support system that directly results in the patient's death requires the direct involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment.
>
> * * *
>
> Once [the patients] are fully informed of their alternatives, and are sure they want the respirator removed even if it will result in their death, they then have the right to have treatment discontinued.

JA 104-05. Doctors are able to determine whether a patient's request to hasten death is rational and competent, or instead is motivated by depression or other mental illness or insanity, and New York practitioners currently make these determinations with respect to orders not to resuscitate and refusal of life-sustaining treatment. JA 114, 116.

Second, like legally prescribed methods, legally proscribed methods require affirmative steps by the patient's doctor:

> At a practical level, *the doctor must take several actions* to carry out the patient's desire. The doctor must *turn off the breathing machine*, *disconnect the machine* from the tube that goes to the patient's lungs, and then *remove the tube* from the patient's lungs. These patients must be carefully monitored after the respirator is withdrawn.

JA 105 (emphasis added).

Third, both methods involve prescribing medication that hastens death. When a respirator is removed, "the doctor usually must also give morphine or barbiturates to ameliorate the patient's sensation of suffocation." *Id.* When hydration and nutrition devices are withdrawn, powerful sedatives are administered. JA 106. Under either circumstance, the medications can and do contribute to death.

> These medications [morphine and barbiturates] must often be used in doses that contribute to the patient's death by suppressing their respiratory drive.

JA 105. *See* JA 106 (patients treated "with sedatives that hasten the patient's death").

III. THE LOWER COURTS' DECISIONS

Respondents concur in the third and fourth paragraphs of petitioners' Statement of the Case, describing the rulings below.

REASONS FOR DENYING THE PETITION

I. THERE IS NO CONFLICT AMONG THE LOWER COURTS

A. There Is No Conflict Between Federal Circuits

The Second Circuit unanimously ruled that New York's law prohibiting assisted suicide violates the Equal Protection Clause because it "does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," and distinctions made with respect to such persons "do not further any legitimate state purpose." *Quill v. Vacco*, 80 F.3d 716, 727 (2d Cir. 1996).

The reasoning of the Ninth Circuit, the only other federal appellate court to consider the matter, is squarely consistent with that of the Second Circuit. The Ninth Circuit concluded that there is no "ethical or constitutionally cognizable" basis upon which to distinguish between physician assistance in hastening death by the act of prescribing medications for that purpose and the act of withdrawing or withholding life support. *Compassion In Dying v. Washington*, 79 F.3d 790, 821-24 (9th Cir. 1996) (en banc). Thus, there is no conflict among the federal appellate courts that have considered the issue of physician assistance in dying.

Recognizing this, petitioners instead assert that the Second Circuit decision is "fundamentally at odds" with that of the Ninth Circuit. Petition for Writ of Certiorari at 15. The Second Circuit's reasoning is "at odds" with the Ninth Circuit's only insofar as the Second Circuit felt constrained to recognize previously unidentified liberty interests. *Quill*, 80 F.3d at 723-25. To the extent there is a conflict between the Second Circuit and the Ninth Circuit on the liberty claim, that is not the basis of petitioners' request for relief. Petitioners prevailed on that issue in the ruling they seek to bring before

this Court for review. Moreover, petitioners' statement of the Questions Presented makes clear that they seek review only of the equal protection analysis.

B. There Is No Conflict Between a Federal Court and a State Court of Last Resort

Petitioners' representation that a conflict exists between the Second Circuit decision and that of a state court of last resort also is inaccurate. The Michigan Supreme Court, which reviewed Michigan's statute prohibiting physician-assisted suicide, was presented only with a Fourteenth Amendment liberty claim, and its holding is limited to that claim. *People v. Kevorkian*, 527 N.W.2d 714, 724, 733 (Mich. 1994) ("We would hold that the Due Process Clause of the federal constitution does not encompass a fundamental right to commit suicide, with or without assistance, and regardless of whether the would-be assistant is a physician."), *cert. denied*, 115 S. Ct. 1795 (1995). The court's footnote reference to the Equal Protection Clause, cited by petitioners at page 15, comprises the Michigan Supreme Court's entire equal protection discussion and is dicta.[1]

Moreover, the Second Circuit's equal protection ruling is based upon a finding that the State of New York, in both statutory and common law, has disavowed an absolute commitment to preserving life. *Quill*, 80 F.3d at 727-29. Thus, the ruling is based on the particulars of New York's statutory and common law and cannot give rise to a conflict,

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[1] In tacit acknowledgment of the absence of any true conflict between the Second Circuit and the Michigan Supreme Court, petitioners cite to a Michigan state trial court decision in which petitioners claim the equal protection claim was "squarely and fully presented." Petition for Writ of Certiorari at 15 n.6. Even if correct, a trial court decision does not create a conflict worthy of this Court's attention. Supreme Court Rule 10.1(a).

even if the Michigan Supreme Court had been presented with an equal protection claim based upon Michigan statutory and common law. The Second Circuit decision turns entirely upon the law of New York and how that state has chosen to empower its citizens in making end-of-life decisions.

At the time the Michigan Supreme Court ruled, Michigan's statutory law was less protective of patient choice than that of New York. For instance, Michigan had not yet enacted a measure permitting the execution of a "do-not-resuscitate order." Even Michigan's 1996 law permitting such orders imposes more obstacles to patient choice than the analogous law in New York. *Compare* 1996 Mi. ALS 193; 1996 Mi. P.A. 193; 1995 Mi. SB 452 § 2(e) (requiring execution of order in writing and permitting compliance with a patient's order only "in a setting outside of a hospital, a nursing home, or a mental health facility") *with* N.Y. Pub. Health Law § 2964(2) (permitting consent to order orally during hospitalization, or in writing prior to or during hospitalization). Michigan's statute governing health care proxies is also more onerous than that of New York. *Compare* Mich. Comp. Laws § 700.496(9)(e) (requiring "clear and convincing" expression of patient's desire to forego life sustaining medical treatment) *with* N.Y. Pub. Health Law § 2982(2) (requiring only that patient's wishes regarding artificial nutrition and hydration be reasonably known or knowable). Thus, were an equal protection analysis conducted of Michigan's statute prohibiting assisted suicide, the conclusion might have been different than that reached by the Second Circuit with respect to New York's law.

Finally, the statute reviewed by the Michigan Supreme Court has expired by its own terms. Mich. Comp. Laws § 752.1027. Thus, even if the Michigan Supreme Court's ruling did present a conflict, that conflict has evaporated. This was recognized by the State of Michigan in its opposition to a petition for writ of certiorari. *Hobbins v. Michigan*, No. 94-

1473 (Oct. Term 1994), Brief for Respondent in Opposition at 13 ("The challenged statute no longer exists. In these circumstances, an order declaring its unconstitutionality and enjoining its enforcement would be meaningless.").

II. REVIEW BY THIS COURT AT THIS TIME IS PREMATURE

Issues surrounding patient choice and physician assistance in hastening death continue to be reviewed by lower courts. For example, respondents are aware that at least one case raising similar issues is pending. *McIver v. Krischer*, CL96-1504AF, Palm Beach Circuit Court, 15th Judicial Circuit, Florida. This suggests that this Court should defer considering these issues at this time.

Sound principles of judicial restraint also counsel against granting review at this time. *See, e.g., McCray v. New York*, 461 U.S. 961, 963 (1983) (certiorari denied where issue requires "further study" in lower courts "before it is addressed by this Court"); *Gilliard v. Mississippi*, 464 U.S. 867, 869 (1983) (Marshall, J., dissent from denial of certiorari to "those of my colleagues who agree with me that . . . these cases present important constitutional questions, but believe that this Court should postpone consideration of the issue until more state supreme courts and federal circuits have experimented with substantive and procedural solutions to the problem"); *California ex. rel. Cooper v. Mitchell Bros.' Santa Ana Theater*, 454 U.S. 90, 98 (1981) (Stevens, J., dissenting from grant of certiorari on grounds of traditional practice of avoiding premature adjudication of constitutional principles).[2]

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[2] Denial of review at this time, of course, would suggest no expression upon the merits of the case. *See, e.g., Maryland v. Baltimore Radio*

III. THE SECOND CIRCUIT CORRECTLY DECIDED THAT NEW YORK PENAL LAW SECTIONS 125.15(3) AND 120.30 DENY EQUAL PROTECTION

In addition to the lack of conflict and prematurity factors disfavoring review at this time, review is also unnecessary because the decision below is correct.

This petition is limited to challenging the application of the rational basis standard in an equal protection analysis of New York's laws governing end-of-life decisions.[3] New York law grants a high degree of patient autonomy over end-of-life decisions. For example, New York permits otherwise healthy people with life expectancies of many decades to refuse life-saving treatment and allows patients to delegate by proxy to others a decision to bring about their death by altering their medical treatment. The record here shows no rational basis for distinguishing the cases of mentally competent, terminally ill patients who seek to end their suffering through self-administered prescription drugs from all the other cases in which New York statutory and common law grants patient autonomy over end-of-life decisions. Petitioners' argument that the writing of a prescription constitutes "active" physician assistance as compared to the "passive" posture involved in withdrawing treatment, such as a respirator or feeding tube, is not supported by the record. In fact, the withdrawal of life support typically involves a whole course of treatment, sometimes lasting days or weeks, which includes the administration of medications, such as morphine, that

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Show, Inc., 338 U.S. 912, 919 (1950); *United States v. Carver*, 260 U.S. 482, 490 (1923).

[3] To the extent that the Second Circuit erred in its analysis, it was by utilizing the lowest standard of review, rather than the heightened standard of review appropriate given the existence of a protected liberty interest.

themselves hasten death. In these circumstances, the petition presents no question warranting this Court's review.

A. New York Law Grants Broad Patient Autonomy Over End-of-Life Decisions

New York's statutory and common law already expressly authorizes patients to make end-of-life decisions with physician assistance in circumstances far less compelling than those here.

New York statutes concerning orders not to resuscitate and health care proxies specifically permit patients to direct their physicians to assist them to die. The New York Public Health Law pertaining to orders not to resuscitate provides that a patient's attending physician must either issue the order or object and transfer the patient to another physician, or submit the matter to dispute mediation. N.Y. Pub. Health Law § 2964(2). The patient need not be terminally ill in order to request an order not to resuscitate. *Id.* §§ 2964(1), 2964(3). When a surrogate is making medical decisions for a patient lacking capacity, the surrogate may request an order not to resuscitate not only if the patient is terminally ill, but also if the patient is permanently unconscious, if resuscitation would be medically futile, or if "resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient." *Id.* § 2965(3)(c)(iv). Section 2976 of the New York Public Health Law suggests that state courts may issue orders not to resuscitate even in circumstances other than those explicitly authorized by the statute.

Under provisions pertaining to health care proxies, a competent principal may appoint a health care agent to make medical decisions for the principal in the event of incapacity according to the "principal's wishes" or the "principal's best interests." *Id.* §§ 2981(1)(b), 2982(2). The agent may make

all decisions regarding life-sustaining treatment except those decisions concerning unascertained wishes regarding artificial hydration and nutrition. There is no requirement that an adult be terminally ill when the decision to request assistance to die is embodied in the proxy or implemented by the agent.

In addition to the rights granted in these statutes, New York common law grants broad rights of patient autonomy. The New York Court of Appeals, quoting Justice Cardozo's view that every human being "'of adult years and sound mind has a right to determine what shall be done with his own body,'" has held:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, *it is the individual who must have the final say* in respect to decisions regarding his medical treatment in order *to insure that the greatest possible protection is accorded his autonomy and freedom* from unwanted interference with the furtherance of his own desires.

Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (recognizing the right of patients to refuse psychotropic medication) (emphasis added) (quoting *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

The patients for whose benefit this action was brought are all:

(1) mentally competent

(2) terminally ill patients

(3) wishing to receive physician assistance through the prescription of drugs that

(4) the patients may choose

(5) to self-administer

(6) to hasten their own deaths.

An analysis of how New York has treated these characteristics in other contexts shows that there is no basis for distinguishing the patients herein from other New York citizens who are granted autonomy over end-of-life decisions.

1. Mental Competence

New York's Public Health Law affirmatively presumes that patients have the mental capacity to make end-of-life decisions. With respect to orders not to resuscitate, the Public Health Law provides that every adult "shall be presumed" to have capacity to make a decision regarding resuscitation. N.Y. Pub. Health Law § 2963(1). A patient has capacity so long as he or she has

> the ability to understand and appreciate the nature and consequences of an order not to resuscitate, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order.

Id. § 2961(3). Similarly, an adult "shall be presumed competent" to make a health care proxy. *Id.* § 2980(3).

Petitioners seek to justify the Penal Law subsections at issue here by presuming that terminally ill patients are depressed or vulnerable. This is an impermissible presumption under equal protection analysis. New York otherwise erects very high barriers to the determination that patients are anything other than fully competent. The statutes pertaining to orders not to resuscitate do not permit a presumption of lack of capacity. *See id.* § 2963(1). Indeed, while one physician is required to confirm that an adult has capacity to consent to an

order, two physicians must concur in a determination that an adult lacks capacity. *Id.* § 2963(3)(a).

The claim that respondents' patients are any more subject to pressure from "uncaring relatives" or physicians "with their own agendas" than the patients empowered by the statutes governing orders not to resuscitate and health care proxies has no support in the record; the disparity in protections afforded these two categories of patients is insupportable under the Equal Protection Clause.

In light of current New York law that presumes patient capacity to make end-of-life decisions, the Second Circuit correctly concluded that the State has no rational basis to presume that the mentally competent patients in question here lack capacity to make end-of-life decisions.

2. Terminal Illness

Petitioners' argument that the Second Circuit left unanswered "the question of whether 'terminal illness' is always readily and accurately identifiable and precisely when, and by what definition a patient should be deemed terminally ill," Petition for Writ of Certiorari at 12, is nonsense given that New York has already defined "terminal condition" by statute.[4] Moreover, the Second Circuit recognized that "New York may define [terminal] illness with more particularity." *Quill*, 80 F.3d at 731.

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[4] The Public Health Law defines a "terminal condition" as "an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year." N.Y. Pub. Health Law § 2961(23). Federal health insurance laws define the term similarly. *See, e.g.*, 42 U.S.C. 1395x(dd)(3)(A).

New York itself places the very real rights of patients above all abstract "state interests." The right to hasten death in New York extends even to individuals who may fully recuperate following treatment, a significantly less compelling circumstance than that in which respondents' patients find themselves. For instance, a patient in New York may consent to an invasive medical procedure, be capable of full and immediate recuperation, and still have the common law right to refuse routine treatment necessary for survival.[5]

3. Physician Assistance in the Form of Prescriptions

Under New York law, medical advice and prescriptions constitute medical services to which a mentally competent, adult patient may consent, and "the consent of *no other person* shall be necessary." N.Y. Pub. Health Law § 2504(1) (emphasis added). Patients in New York hospitals are protected as follows:

> Every patient's civil and religious liberties, including the right to independent personal decisions and *knowledge of available choices*, shall not be infringed and the facility *shall en-*

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[5] The New York Court of Appeals held in *Fosmire v. Nicoleau*, 551 N.E.2d 77, 80-81 (N.Y. 1990), that a competent adult's common law "right . . . to determine the course of his or her own medical treatment" included the right of a healthy young mother to decline blood transfusions following delivery of a child by cesarean section. *Accord Erickson v. Dilgard*, 252 N.Y.S.2d 705, 706 (N.Y. Sup. Ct. 1962) (competent, informed adult may refuse blood transfusion after amputation because he "has the final say . . . in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires"). Thus the law currently allows essentially healthy patients, with substantial life to preserve, the right to bleed to death under a physician's care.

courage and assist in the fullest possible exercise of these rights.

Id. § 2803-c(3)(a) (emphasis added). In addition, every patient has the right to receive full information about his or her medical condition and to private physician consultations and treatment. *Id.* §§ 2803-c(3)(b), 2803-c(3)(e).

Physicians already prescribe medications that "contribute to" or "hasten" the patient's death in the course of assisting patients disconnected from life support to die. JA 105-06. These physicians are protected both by statute and by the common law. Furthermore, physicians have the right to abstain from assistance under the current law, as they will in any end-of-life scenario.

4. Patient Choice

New York has already decided that the State's interests most appropriately lie with patient choice, and acknowledges that end-of-life decisions involve consideration of the patient's religious and moral beliefs and the patient's best interests. N.Y. Pub. Health Law §§ 2965(3)(a), 2973(1), 2976(1). *See id.* § 2803-c(3).

In addition, the State's courts have concluded that New York's common law "right of self determination" provides the foundation for a competent adult patient's right to control his or her medical treatment even if the effect is to hasten death. *Rivers*, 495 N.E.2d at 341 (N.Y. 1986); *Delio v. Westchester County Medical Ctr.*, 516 N.Y.S.2d 677, 691-93 (N.Y. App. Div. 1983).

There can be no dispute that the State has given the widest latitude to a patient's right to choose the course of his or her own treatment.

5. Self-Administration of Drugs

Disconnecting life support equipment and providing medication contributing to death is in no way distinguishable from the assistance sought here.

Removal of life support requires health care professionals to participate actively in and monitor the process of dying. As Dr. Quill described it, to carry out a patient's desire for removal of life support, the doctor must take "several actions." JA 105. He must (1) turn off the breathing machine, (2) disconnect the machine from the tube that goes to the patient's lungs, (3) remove the tube from the patient's lungs, (4) give morphine or barbiturates, sometimes in continuous infusions and "in doses that contribute to the patient's death," and (5) provide ongoing monitoring. JA 105-06. Physicians "actively and openly assist [patients] to die," and that active participation "often includ[es] medical interventions that contribute to an earlier death." JA 107. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 296-97 (1990) (Scalia, J., concurring) (noting "irrelevance of action-inaction distinction").[6]

Petitioners' characterization of death by removal of life support as "natural" is belied by the reality of the process of dehydrating or suffocating to death over an excruciating period of days or weeks. The patient for whom removal of a respirator or feeding tube remains as the only option for a "natural" death has reached that point only after experiencing numerous profoundly unnatural treatments. *See* JA 115. *See* Howard Brody, *Assisted Death — A Compassionate*

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[6] Petitioners have not and cannot identify any controlling authority to the contrary. Other than Justice Scalia's view that there is no distinction between so-called "active" and "passive" assistance, this Court has not expressed its view on this issue.

Response to a Medical Failure, 327 New Eng. J. Med. 1384, 1385 (1992) (medical technology has "extended the patient's life and resulted in the complications that have brought the patient to the present state of suffering" and set them up "for what many consider an unacceptable way of dying"); *see generally* Betty Rollin, *Last Wish* (1985) (describing mother's death from cancer).

In *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 641 n.2 (Mass. 1986), the dissent described the result of a physician disconnecting a gastronomy tube through which the patient had received nutrition and hydration:

> Removal of the G tube would likely create various effects from the lack of hydration and nutrition, leading ultimately to death. Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His tongue would swell, and might crack. His eyes would recede back into their orbits and his cheeks would become hollow. The lining of his nose might crack and cause his nose to bleed. His skin would hang loose on his body and become dry and scaly. His urine would become highly concentrated, leading to burning of the bladder. The lining of his stomach would dry out and he would experience dry heaves and vomiting. His body temperature would become very high. His brain cells would dry out, causing convulsions. His respiratory tract would dry out, and the thick secretions that would result could plug his lungs and cause death. At some point within five days to three weeks his major organs, including his lungs, heart, and brain, would give out and he would die. *The [trial] judge found that death by dehydration is extremely painful and uncomfortable for a human being.* The judge could not rule out the possibility that Paul Brophy could experience pain in such a scenario. *Paul Brophy's attending physician described death by dehydration as cruel and violent.*

(Emphasis added) (Lynch, J., dissenting). *See* JA 106 (the process of dehydrating, starving, losing control of mental and physical capacities, experiencing organ failure, passing into unconsciousness and dying with the help of medical personnel may take seven to 10 days or more). Other forms of withholding treatment are no more "natural." *See* JA 105 ("Since respiratory failure can be one of the most excruciating and frightening deaths possible, the doctor must also give morphine or barbiturates to ameliorate the patient's sensation of suffocation."); Helga Kuhse, *The Case for Active Voluntary Euthanasia*, 14 Law, Med. & Health Care 145, 147 (1986) (respiratory death involves "conscious air hunger," "gasping, an increased breathing rate, a panicked feeling of inability to get air in or out;" in death from withholding of dialysis, the patient remains conscious and experiences nausea, vomiting of blood and convulsions).

The only difference between allowing a dying patient to take a lethal dose of medication to hasten impending death and removing equipment and infusing medication during a prolonged period before death ensues is that the former is more humane. JA 107.

6. Hastening One's Own Death

In *Cruzan*, this Court acknowledged that a patient may direct the removal of life support with the intent of "caus[ing] her death." 497 U.S. at 267-68, 278. Other courts similarly acknowledge that a state interest in the prevention of irrational self-destruction is not at issue in reviewing a

competent, rational decision to direct the removal of life support when death is imminent. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977).

The State of New York permits patients to choose to hasten death in such extensive circumstances as to leave no room for denying that choice to other mentally competent, terminally ill adults. In *Fosmire* the New York Court of Appeals determined that a young mother had a common law right to bleed to death by refusing blood transfusions, despite the fact that she had consented to a cesarean section.[7] 551 N.E.2d 77.

Moreover, New York draws a distinction between the State's interest in a private decision that injures the public and a private decision that affects only the person making the decision.

> The State has a well-recognized interest in protecting and preserving the lives of its citizens. . . . In these instances [of withdrawal of treatment], it has been noted, a distinction should be drawn between the State's interest in protecting the lives of its citizens from injuries by third parties, and injuries resulting from the individual's own actions. When the individual's conduct threatens injury to others, the State's interest is manifest and the State can generally be expected to intervene. But the State rarely

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[7] Certainly a physical condition that results from informed consent to surgery should be considered "self-inflicted" to a much greater extent than a terminal illness. Similarly, a patient suffering from a terminal illness does not "want to die" any more than, or even as much as, a woman who chooses to bleed to death because of religious convictions.

> acts to protect individuals from themselves, indicating that the State's interest is less substantial when there is little or no risk of direct injury to the public. This is consistent with the primary function of the State to preserve and promote liberty and the personal autonomy of the individual. In many if not most instances the State stays its hand and permits fully competent adults to engage in conduct or make personal decisions which pose risks to their lives or health.

Id. at 81 (citations omitted). After *Fosmire*, the State simply cannot justify a blanket prohibition of a private decision that "injures" only the person making the decision. Indeed, the option of a humane, hastened death confers a benefit, not an "injury," to patients making this profoundly personal choice.

B. The Challenged Laws Deny Equal Protection

The Equal Protection Clause prohibits the State of New York from treating similarly situated individuals differently. *Plyler v. Doe*, 457 U.S. 202, 216 (1982); *F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920). Classifications drawn by state law must be rationally related to a legitimate state interest. *Romer v. Evans*, 64 U.S.L.W. 4353, 4357, 1996 U.S. LEXIS 3245 at **25-26 (May 20, 1996) ("finding it impossible to credit" Colorado's assertion that a state constitutional amendment prohibiting preferential status for homosexuals protected the freedom of association and other liberties of landlords, employers and others with personal or religious objections to homosexuality, or that the amendment would conserve state resources for use in fighting discrimination against other groups); *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985) (city failed to provide rational reasons why facilities for the mentally retarded would warrant zoning treatment distinct from the

treatment afforded facilities inhabited by fraternities, sororities, and other multiple dwelling facilities).

Applying these principles, the Second Circuit correctly decided that New York Penal Law sections 125.15(3) and 120.30 violate the Equal Protection Clause because the distinction New York draws between competent, terminally ill patients whose treatment involves life-sustaining equipment and those whose treatment does not involve such equipment is not rationally related to any legitimate state interest.[8]

CONCLUSION

For these reasons, the Petition for Writ of Certiorari should be denied.

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[8] In addition, the decision below can be affirmed on the alternative constitutional basis argued below, namely, the Fourteenth Amendment's guarantee of liberty. *See, e.g., Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 38-39 (1989); *Washington v. Yakima Indian Nation*, 439 U.S. 463, 476 n.20 (1979).

Respectfully Submitted,

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